Medigap Coverage for Prescription Drugs

Statement of
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Testimony before the U.S. Senate Committee on Finance
Finding the Right Fit: Medicare, Prescription Drugs and Current Coverage Options

Washington, DC
April 24, 2001

Mr. Chairman and Members of the Committee:

Thank you for inviting me to comment on the role of Medigap policies in providing coverage for prescription drugs, and on the potential impact of a Medicare drug benefit on Medigap policyholders, insurers and the market. My comments today are directed to the vast majority of Medigap policyholders: elderly Medicare beneficiaries. The problems that disabled Medicare beneficiaries face in finding and affording Medigap coverage for prescription drugs surely warrant separate consideration: disabled Medicare beneficiaries spend much more out of pocket for prescription drugs than the elderly even when they have Medigap coverage for drugs, and they are less likely than the elderly to have any Medigap coverage at all (NAIC, 2000; Poisal and Murray, 2001). Disabled Medicare beneficiaries comprise just one percent of all Medigap policyholders (NAIC, 2000).

I. How many Medicare beneficiaries have Medigap coverage for prescription drugs?

In 1989, Congress enacted legislation that standardized commercial Medigap products in order to simplify the Medigap market and eliminate the selling of redundant coverage to Medicare beneficiaries. Since July 1992 (the law's effective date), insurers have been allowed to sell only 10 standard Medigap products, either directly to individuals or though associations. These policies are identified by letter, A through J; policy form A is the Medigap basic benefit, and all other standard policy forms contain variations of additional benefits. Only policy forms H, I and J offer any coverage for prescription drugs.

While insurers were required to standardize new coverage, they were permitted to renew indefinitely all policies issued before July 1992, without converting them to a standard product design. As a result, nearly 1/3 of Medigap policyholders still have prestandard policies.

About 1/4 of all Medicare beneficiaries have Medigap coverage, and just 6 percent of these were enrolled in standard policies that covered prescription drugs — H, I or J plans — in 1999 (Poisal and Murray, 2001; Chollet, forthcoming). Of all Medicare beneficiaries who have purchased Medigap policies since mid-1992, just 9 percent have purchased policies that cover prescription drugs.

The large number of Medigap policyholders with prestandard coverage seem likely to have at least some coverage for prescription drugs, although in fact the benefit designs of these policies are not known. Comparing the number of covered lives that insurers report in prestandard Medigap products to population survey estimates of Medicare beneficiaries with individual (not employer-sponsored) private supplemental insurance,[1] it would appear that nearly all prestandard plans have some coverage for prescription drugs. If we assume this is the case, then in total nearly 40 percent of Medigap policyholders probably have coverage for prescription drugs. Of these, about 3/4 have prestandard coverage.

Even this moderate rate of prescription drug coverage among Medigap policyholders, however, varies from state to state. In a few states, more than half of Medigap policyholders (including all prestandard and H, I, or J policyholders) probably had some coverage for prescription drugs in 1999. But in several other

[1]Estimates from the Medicare Current Beneficiary Survey indicate that 39.9 percent of beneficiaries with only Medigap insurance have coverage for prescription drugs (Poisal and Murray, 2001).

states, fewer than 25 percent — and as few as 6 percent — of Medigap policyholders had any coverage for prescription drugs (Chollet and Kirk, forthcoming). There is no available research that would explain the substantial state-to-state differences in the level and type of Medigap coverage we observe.

II. What do Medigap policies cover?

For Medigap policyholders with standard coverage for prescription drugs, that coverage is very limited. And for 3 out of 4 Medigap policyholders who probably have some prescription drug coverage -- those with prestandard Medigap policies -- coverage for prescription drugs appears to be even more limited.

A. Standard Medigap policies

Each of the three standard Medigap products that covers prescription drugs offers only very limited drug coverage. H and I plans have the same coverage design for prescription drugs; J plans have a higher limit on plan benefits (see Table 1.) However, all leave policyholders with unlimited out-of-pocket expenditures for drugs, and all require 50% cost-sharing. H and I policies pay as much as $1,250 per year for prescription drugs; J policies pay as much as $3,250. However, to reach this level of coverage, policyholders must spend out-of-pocket $2,000 (in H and I plans) or $3,250 (in J plans) — the amount of the policies' deductible and maximum coinsurance. Above the plan's annual limits on coverage for prescription drugs ($2,500 and $6,000 per year, respectively), the policyholder has no coverage for the balance of the year.

B. Prestandard Medigap policies

Information from insurers suggests that prestandard coverage for prescription drugs is probably less than that offered in standard H or I plans. AARP's prestandard Medigap policy appears to cover about one-third of Medicare beneficiaries in prestandard Medigap policies; AARP's prestandard policy has a 50% coinsurance rate and a $500 annual cap on the drug benefit.

Other evidence also suggests that drug coverage in many prestandard plans is much more modest than that in standard plans. Because prestandard policies have not been sold to new Medicare beneficiaries in nearly a decade, all prestandard policyholders are now at least age 74, and their use of prescriptions drugs probably is higher than that of younger beneficiaries in standard plans. However, in 1999, the average prestandard plan was about as expensive as a standard H or I plan nationally and in most states (Chollet and Kirk, forthcoming).

C. Evidence of limited Medigap coverage for prescription drugs

Beneficiaries with individual insurance coverage averaged twice the level of out-of-pocket spending for drugs as beneficiaries with employer-sponsored retiree coverage. In 1998, median out-of-pocket spending for prescription drugs among Medigap policyholders with drug coverage was $318, compared to $181 for beneficiaries who reported having drug coverage from an employer-sponsored retiree plan (Poisal and Murray, 2001). Both groups of Medicare beneficiaries reported about the same number of prescriptions per year — 23 versus 24.

On average, Medigap policies paid just 42 percent of policyholders' prescription drug costs, compared to 71 percent of costs among beneficiaries with employer-sponsored retiree coverage (Poisal and Murray, 2001). The average rate of insured drug expenses among Medigap policyholders reflects their policies' very

high cost-sharing rates — typically, 50% after the deductible. It also suggests that most Medigap policyholders incurred expenses within their policy's limit on benefits. However, some obviously exceeded their coverage limits, and potentially by substantial amounts.

III. Problems of access to Medigap coverage for prescription drugs

While many insurers write Medigap coverage, many write very small amounts of business in some states, often just a few lives. This pattern reflects two aspects of the Medigap market. First the barriers to moving among carriers and policies are substantial, even as policyholders relocate to other states. Second, in many states, large numbers of Medigap insurers are renewing policies, but they are not issuing new policies. Among insurers that are issuing new policies, many are not actively marketing and have issued no new policies in several years in most of the states where they do business.

Medicare beneficiaries' problems of access to Medigap coverage for prescription drugs, however, are more complex than just finding a carrier currently selling coverage. The Medigap market is extensively underwritten — insurers are selective about whom they sell policies to. Few states require insurers to offer any Medigap product guaranteed issue, except within six months of enrollment in Medicare at age 65, and then again within six months for a carrier's own policyholders who wish to change plans. Massachusetts (one of three states with a waiver of Federal rules governing Medigap products) is the only state that requires Medigap insurers to offer periodic open enrollment in all Medigap products. In all other states, Medigap insurers may deny coverage in all or most policies that they offer — *including all that cover prescription drugs* — for any applicant after age 65.

As a result of these rules, the vast majority of Medicare beneficiaries have access to a Medigap plan that covers prescription drugs literally only once in their lives — within a year of enrolling in Medicare at age 65. When beneficiaries are able to change Medigap policies after age 65, the insurer may restart a 6-month waiting period for coverage of preexisting conditions.

A. The supply of Medigap coverage for prescription drugs

Across all states, only about half of Medigap insurers were actively marketing Medigap coverage in 1999. And while, averaged nationally, about as many insurers sell H, I, or J policies as sell other policy forms, this pattern varies by state. In several states, just one insurer reported having any open standard Medigap product with prescription drug coverage in 1999 (NAIC, 2000; Chollet and Kirk, forthcoming).

In all states, a guaranteed-issue Medigap policy covering prescription drugs (H, I, or J) was available in at last some part of the state in 1999. However, with very few exceptions, only one or two insurers offered a guaranteed issue H, I or J policy, and enrollment in these policies was very low. Just 2 percent of Medicare beneficiaries with standard Medigap coverage were enrolled in guaranteed issue H, I, or J policies in 1999 (Chollet and Kirk, forthcoming).

B. The price of Medigap coverage for prescription drugs

Standard Medigap premium quotes offer only a rough indicator of actual premium differences among products, and they do not reflect the rating factors (age and gender) that insurers apply to most Medicare

beneficiaries. Standard premiums vary widely among carriers for the same policy form.[2] These differences probably reflect noncompetitive pricing, different rating methodologies[3] or both. Moreover, there are strong geographic differences in premiums for the same products and rate classes, probably reflecting geographic variation in enrollment, health status and service use — as well as regional variation in competition and prevailing (or prohibited) rating methodologies. Beneficiaries older than age 65 pay a mark-up on the standard premium that reflects their age cohort and also (if accepted for coverage after age 65) their health status. Moreover, women may pay a higher premium in every age cohort than men.

For these reasons, it is very difficult to relate a standard premium quote for one rate class to the premiums that Medigap policyholders actually pay. Nevertheless, examining the level and variation of even standard rates for a single rate class is enlightening when considering why so few Medicare beneficiaries purchase Medigap policies that cover prescription drugs and whether insurers are likely to continue offering these policies.

With funding from HCFA, Weiss Ratings, Inc. recently published rate quotes compiled from all Medigap insurers with open products (just less than half of all Medigap insurers with products in force) in 1998, 1999 or 2000. These rate quotes for men at age 65 — typically the lowest rate class — are summarized in Table 2.

Three aspects of these rate quotes are especially notable:

- First, *relative to any measure of the elderly's income, the average price of a Medigap policy with prescription drug coverage is extremely high.* The average standard (and lowest) price of H coverage in 1999 was equivalent to nearly 13 percent of median gross income among the elderly, and more than 8 percent of average gross income. The average standard price of a J plan was equivalent to 19 percent of median gross income and more than 12 percent of average gross income. The very high absolute cost of Medigap policies that include prescription drug coverage probably explains the very low rate of purchase (less than 6 percent) among new Medicare beneficiaries over the last decade.

- Second, *average standard rates for H and I products in 2000 were at least 80 percent more expensive than for the most popular Medigap product, policy form F.* The average premium for policy form J — which offers a $3,000 maximum drug benefit with 50% coinsurance — was nearly 2 ½ times the average premium for policy form F. All other policy forms (some of which contain non-drug benefits much more similar to H, I or J than F) were less expensive than F, averaged nationwide. These price differences at age 65 are probably the

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[2]Weiss Ratings, Inc. (1999) reported standard rates for plan A of $496 (Labor Union Life) and $1,220 (Bankers Life and Casualty Company) for a man at age 65 in Bakersfield, CA. In Billings, MT rate quotes for a J plan included $1,518 (Blue Cross Blue Shield of MT) and $3,453 (National States Insurance Company).

[3]Insurers may rate Medigap polices on an entry-age (or issue-age) basis, on an attained-age basis, or on a community-rated basis. As of May 1999, at least six states prohibited Medigap insurers from using entry-age rating, at least ten prohibited attained-age rating, and at least 8 required community rating (NAIC, 2000).

main reason that Medicare beneficiaries at age 65 are unlikely to buy Medigap policies with drug coverage. After age 65, Medicare beneficiaries may be denied access to drug coverage at any price, if they are unable to identify one of the few Medigap insurers with an open, guaranteed issue product.

- Third, *the annual growth in premiums for Medigap products that covered prescription drugs has been extraordinary, apparently causing problems for both beneficiaries and insurers*. Rate quotes for H plans in 2000 were nearly 50 percent higher than in 1998; in one year (1999-2000), standard premiums in H plans jumped 34 percent. Standard rates for I and J plans also rose steeply (34 percent and 27 percent, respectively, between 1998 and 2000).[4] By comparison, standard rates for F plans rose just 12 percent between 1998 and 2000, approximately 6 percent per year.

Very high premium growth is very problematic both for policyholders with health problems and for Medigap insurers. Medicare beneficiaries who drop H, I or J coverage because they are unable to pay escalating premiums may have no alternatives available to them other than plan A (if their insurer is willing to down-grade their coverage to A) or a Medicare+Choice plan (if one is available in their area). The somewhat faster growth of standard rates charged for plan A coverage (which every Medigap insurer is required to sell) suggests some high-risk people may in fact be moving into plan A from other standard Medigap policies. Policyholders who abandon Medigap policies that are entry-age priced also abandon an asset — the front-loaded premiums that they paid in earlier years -- and pay a penalty to enter any other entry-age rated Medigap plan, even if they are able to pass the insurer's underwriting screen.

For Medigap insurers, rapidly increasing premiums can generate an adverse selection spiral (sometimes called a "death spiral") — a phenomenon in which rising premiums encourage healthier policyholders to abandon coverage, and the higher medical costs of remaining policyholders then drive still higher premiums. The fact that Medigap policyholders are aging faster than the Medicare beneficiaries suggests that adverse selection is a growing problem in the Medigap market as a whole, as well as for individual Medigap insurers.[5]

Concerned about an adverse selection spiral, insurers are likely to close products where costs and therefore premiums are escalating rapidly. The propensity of insurers to close policies that have poor cost

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[4]Evidence offered in an NAIC survey of states suggests that Medigap premiums rose steeply in earlier years as well. Between 1996 and 1998, average standard rates for Medigap policies (in 43 responding states) rose 22 percent. Only about 1/2 of this increase was attributed to an increase in Medigap costs for Medicare-covered services (NAIC, 2000).

[5]The American Academy of Actuaries (2000) concluded that the block of standard Medigap policyholders is aging, both for new issues and renewals. Between 1996 and 1998, the average age in both groups increased by one year. Over the same period, the number of Medigap policyholders declined, as the number of Medicare beneficiaries rose. These trends suggest a growing problem of adverse selection in the Medigap market overall.

experience probably explains the large number of Medigap insurers carrying closed blocks of business and the relatively small number actively marketing coverage to Medicare beneficiaries.

III. Implications of a Medicare drug benefit on beneficiaries and existing Medigap coverage

On the whole, a Medicare drug benefit could have a very positive impact on Medigap policyholders and also on the Medigap market. Obviously, it would assist most Medigap policyholders who have no coverage at all for prescription drugs and who are locked out of prescription drug coverage after age 65. However, a Medicare drug benefit also could address at least three serious and growing problems in the Medigap market:

- Medigap lock-in in prestandard plans;
- very fast growth of premiums for Medigap policies that cover prescription drugs; and
- the failure of competition among Medigap policies that cover prescription drugs.

None of these problems in the Medigap market is likely to be addressed successfully except at the federal level.

A. Medigap policyholders without coverage for prescription drugs

Most Medigap policyholders — about 60 percent — have no coverage for prescription drugs. These include 90 percent of all Medicare beneficiaries who have purchased Medigap coverage in the last ten years (that is, those in standard Medigap plans). The low rate of purchase among new beneficiaries reflects both the very high price of these plans relative both to any measure of income among the elderly and also relative to other standard Medigap plans that do not include this coverage. The fact that new Medicare beneficiaries are less likely to buy any Medigap coverage than their predecessors suggests that even the current low rate of prescription drug coverage among new Medicare beneficiaries will continue decline. Underwriting restrictions in the Medigap market make it very difficult for Medicare beneficiaries to buy new prescription drug coverage at any time after age 65.

B. Medigap lock-in for aging Medicare beneficiaries

Three out of four Medigap policyholders with prescription drug coverage are in prestandard Medigap plans. These plans apparently offer very meager coverage for drugs. But all policyholders in these plans are now at least age 74. Because in most states Medigap insurers may deny issue to Medicare beneficiaries after age 65, prestandard policyholders typically have no alternative Medigap option other than plan A (if their current carrier is willing to downgrade their coverage) or a Medicare+Choice plan (if an M+C plan is available in their area). If they enter an M+C plan and wish to leave (or the plan withdraws), they may not reenter their prestandard plan — and they are not guaranteed issue into any standard Medigap product that covers prescription drugs. Lock-in for Medigap policyholders — in either standard or prestandard plans — is already a serious problem, and it is likely to worsen especially for policyholders in prestandard plans.

C. Very fast growth of premiums for Medigap coverage of prescription drugs

Nationwide, expenditures for prescription drugs have increased markedly over the last several years. Because Medicare beneficiaries in general use more prescription drugs than other insured populations, growth in drug prices and utilization inevitably affect the cost of Medigap policies more than the cost of private insurance for the working population, despite the limited drug benefits available in Medigap plans.

The very fast growth of premiums for Medigap policies that cover prescription drugs — at least 50% over the last two years for plan H, the least expensive standard plan with drug coverage — is an obvious and serious problem. Fast premium growth forces some policyholders to abandon their Medigap coverage. Many may have no alternative option that would provide drug coverage. Moreover, they may be unable to qualify for any alternative Medigap coverage at all, unless they live in one of few states that require insurers to hold periodic open enrollment in A plans, at least for current policyholders.

Spiraling premiums for insurance products, however, create other problems of access. Insurers often respond to spiraling premiums by closing their products; that is, they are likely (under pressure from state insurance commissioners) to continue to renew existing coverage, but not to sell any new coverage. Obviously, a scarcity of insurers actively marketing coverage poses problems even for new beneficiaries, and it may worsen older beneficiaries' problems of access as well.

D. Failure of competition in Medigap coverage for prescription drugs

It is likely that at least one reason for the rapid growth in even the lowest premiums (for men at age 65) for standard Medigap coverage that covers prescription drugs relates to the disadvantage that Medigap policyholders have in buying prescription drugs. Medigap policyholders pay full retail price. The diffusion of insurers' business across many states (following policyholders as they move) and the limited coverage of prescription drugs in Medigap plans provide no particular capability or incentives for Medigap insurers to bargain with prescription drug manufacturers or retailers for lower prices. Federal agencies and state Medicaid programs pay substantially lower prices for prescription drugs than many other purchasers — most especially individuals who are either uninsured or, the equivalent, buy coverage from a passive insurer.

The range of standard premiums among insurers in the same market, for identical standard plans, suggests that even new Medicare beneficiaries still have trouble finding their way in the Medigap market. Thus, even if Medigap insurers were able to negotiate preferred prices for significant blocks of business in selected states, it is unlikely that they would be rewarded with much new market share.

Moreover, if some insurers were to enable access to prescription drugs at reduced prices (thereby reducing premiums for Medigap policies that cover prescription drugs), they might be ill-advised to do so. In effect, these insurers would position themselves for adverse selection by Medicare beneficiaries who, at age 65, have an immediate need for prescription drugs. For these reasons — problems of consumer information and fear of adverse selection — it is unlikely that any Medigap insurer would elect to negotiate preferred prescription drug prices for policyholders, even in states where they may hold relatively large blocks of business.

IV. Concluding observations

In summary, the Medigap market is not now a good source of coverage for prescription drugs, and there are many reasons to expect that it will become much worse. Of all Medigap policyholders with prescription

drug coverage, 3/4 are in locked in prestandard plans, with M+C plans as their only potential alternative source of coverage for prescription drugs. Only 9 percent of Medicare beneficiaries in the past ten years have purchased any Medigap plan that covers prescription drugs.

Medicare coverage of prescription drugs might offer advantages both to policyholders and insurers in the Medigap market. On the whole, these advantages would appear to outweigh any disadvantages. Medicare drug coverage would supplant at least some existing Medigap coverage for drugs, but it would offer an opportunity to restructure drug coverage in standard Medigap plans to provide more rational and adequate coverage — such as retirees in employer-sponsored retiree plans have. It also could allow Medigap policyholders to purchase prescription drugs at less than "full retail" prices; these prices have become increasingly steep as large buyers (including Federal and state governments) have negotiated preferred prices. And, finally, by stemming the hyper-growth of Medigap premiums for policies that cover prescription drugs, Medicare coverage of prescription drugs could stabilize the Medigap market — offering some cost relief to consumers who are locked into Medigap policies, and also a remedy to insurers that ultimately will close Medigap policies experiencing steeply rising costs.

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Table 1
Prescription Drug Coverage in Standard Medigap Policies

Drug expenses	Plan pays	Policyholder pays
H and I plans:		
• First $250/year	$0	$250
• Next $2,500/year	50% *Maximum benefit: $1,250/year*	50%
• Over $2,500/year	$0	All costs
J plans:		
• First $250/year	$0	$250
• Next 6,000/year	50% *Maximum benefit: $3,000/year*	50%
• Over $6,000/year	$0	All costs

Source: U.S. Health Care Financing Administration (2001).

Table 2

Standard Medigap Premiums for a Male, Age 65

	Policy form:									
	A	B	C	D	E	F	G	H	I	J
1998	$631	$875	$1,065	$900	$936	$1,164	$1,071	$1,573	$1,803	$2,408
1999	$698	$947	$1,151	$988	$1,069	$1,233	$1,131	$1,747	$1,980	$2,624
2000	$766	$1,026	$1,239	$1,050	$1,107	$1,301	$1,175	$2,347	$2,423	$3,065
As a percent of premium for policy form F:										
1998	54.2%	75.2%	91.5%	77.3%	80.4%	100.0%	92.0%	135.2%	155.0%	206.9%
1999	56.6%	76.8%	93.3%	80.2%	86.7%	100.0%	91.7%	141.7%	160.6%	212.8%
2000	58.9%	78.9%	95.2%	80.7%	85.1%	100.0%	90.3%	180.4%	186.2%	235.6%
Percent change:										
1998-2000	21.4%	17.3%	16.4%	16.6%	18.2%	11.8%	9.8%	49.3%	34.4%	27.3%
1999-2000	9.8%	8.4%	7.7%	6.2%	3.5%	5.5%	3.9%	34.4%	22.4%	16.8%

Source: Weiss Ratings, Inc., 2001 (www.weissratings.com/NewsRelease/Latest/index.html).